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Rev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 21 1943
Registration District No. 518

Primary Registration District No. 1003

Registrar's No. 8077

1. PLACE OF DEATH:

(a) County St. Louis, Missouri.

(b) City or town _____
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital
(If not in hospital or institution, write street number or location) 0

(d) Length of stay: In hospital or institution 4 days (Specify whether _____)

In this community 2 Years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL") 269

(d) Street No. 1454 Madison St.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Jim Mullen

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex M 0

5. Color or race W

6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife P. V.

6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased 6 17 1865
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

78 : 2 : 22 hr. _____ min.

9. Birthplace Mississippi 1
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name Unknown 9

13. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

14. Maiden name Unknown 9

15. Birthplace Unknown 9
(City, town, or county) (State or foreign country)

16. (a) Informant Lucille Mullen

(b) Address 2043 Park Ave

17. (a) Ship (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ship to Poplar Bluff Mo.

18. (a) Signature of funeral director A. W. McLaughlin

(b) Address 2301 Lafayette

19. (a) SEP 16 1943 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 9th
year 1943 hour 5:00 minute _____ P.M.

21. I hereby certify that I attended the deceased from Sept. 5th
1943, to Sept. 9th, 1943;
that I last saw him alive on Sept. 9th, 1943;
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Hemorrhage from cerebral vessel, due to
Hypertensive Cardio-Vasc.
Due to hypertensive disease
Due to Disease

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____ 95

Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work _____ (Specify type of place)

(e) Means of injury _____

23. Signature W. Mad... (M. D. or other) _____
Address 1515 Lafayette Ave. Date signed 9/10/43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed..... *L. B. Cooper*

Licensed Embalmer No. *3633*

P. O. Address *2317 Lafayette*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.